DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT: **REQUEST FOR CHANGE OF PROVIDER**	POLICY NO. **200.2**	EFFECTIVE DATE **01/01/03**	PAGE **1 of 4**
APPROVED BY:  Director	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) **2**

PURPOSE

1.1 To delineate the specific reporting requirements of the Medi-Cal Specialty Mental Health Services Consolidation waiver program from the Center of Medicare and Medicaid Services (CMS) with regard to children with special mental health needs.

1.2 To comply with the State Department of Mental Health request that Mental Health Plans (MHP) adopt these reporting requirements for **all Medi-Cal** beneficiaries seen through the mental health plan, regardless of age.

DEFINITIONS

2.1 **CHILDREN WITH SPECIAL HEALTH CARE NEEDS ARE MEDI-CAL BENEFICIARIES UNDER THE AGE OF 19**, if they are:

2.1.1 eligible for Medi-Cal based on their eligibility for Supplemental Security Income/Blind/ Disabled (SSI) Foster Care programs or Adoption Assistance programs;

2.1.2 enrolled in Home and Community Based Service Model waiver programs; or

2.3.1 receiving services from the California Children's Services (CCS) program.

2.2 **PROVIDER**

2.2.1 Includes individual, group and organizational providers and any service delivery staff within a group or organizational provider.

2.3 **VOLUNTARY CHANGE**

2.3.1 Only changes of provider that are the result of **beneficiary requests** constitute "voluntary changes in outpatient specialty mental health providers".

2.3.2 The following occurrences **do not** constitute a "voluntary change of provider".

2.3.2.1 A beneficiary changes provider due to staff turnover, staff reorganization or termination of a provider contract;

2.3.2.2 A beneficiary moves to a different geographic area within the County and, therefore, changes service locations and providers;

2.3.2.3 A beneficiary transitions from a children's provider to an adult provider;

2.3.2.4 A beneficiary is discharged from the system.

POLICY

3.1 Los Angeles County Department of Mental Health (DMH) shall report to the State Department of Mental Health, no later than October 1 of each year, the number of Medi-Cal beneficiaries who voluntarily change their outpatient mental health provider during the fiscal year pursuant to Title 9; California Code of Regulations (CCR), Section 1830.225. The report shall be based on data from the prior fiscal year.

3.2 DMH shall report to the State Department of Mental Health, no later than October 1 of each year, the number of complaints raised through the MHP's beneficiary problem resolution process, including complaints and grievances as described in Title 9; (CCR), Section 1830-205.

3.3 DMH's Performance, Excellence and Quality Improvement Council (PEQIC) will review data from the Beneficiary Services Program in the Patients' Rights Office regarding Requests for Change of Provider on a quarterly and annual basis. Appropriate action will be taken based on the data.

PROCEDURE

4.1 DMH recognizes that beneficiaries/clients have the right to request a change of provider (i.e., psychiatrist, psychologist, psychiatric social worker, case manager, therapist, etc.) to achieve maximum benefit from mental health services. Every effort will be made to accommodate such requests.

4.2 Beneficiaries/clients may request a change of provider by completing and submitting the "Request for Change of Provider" form. (Attachment I)

4.2.1 "Request for Change of Provider" forms shall be available in the waiting area of each provider location.

4.2.2 Beneficiaries/clients may request assistance with completing the "Request for Change of Provider" form from any mental health staff or Patients' Rights advocate.

4.2.3 Completed "Request for Change of Provider" forms may be given to the receptionist.

4.3 All submitted "Request for Change of Provider" forms shall be collected by the Program Manager at the end of each working day and **maintained in a separate administrative file.**

4.3.1 "Request for Change of Provider" forms shall be retained by the Program Manager for two years.

4.3.1.1 "Request for Change of Provider" forms shall be reviewed by the agency's Quality Improvement Committee, as appropriate and trends analyzed.

4.3.2 In addition to the "Request for Change of Provider" forms, Program Managers shall maintain a "Request to Change Provider Log". (Attachment II) Copies of the logs will be sent to the Beneficiary Services Program in the Patients' Rights Office on a monthly basis.

4.3.3 The "Request to Change Provider Log" shall be retained by the Beneficiary Services Program for two years.

4.4 Program Manager shall attempt to accommodate all beneficiary/client requests to change providers.

4.4.1 The beneficiary/client is under no obligation to provide any reason for his/her request to change providers. However, in order to improve the quality of programs and understand the nature of the request, Program Managers should attempt to obtain information regarding the request from the beneficiary/client. The program may be able to clarify a misunderstanding or resolve a concern at a level that is satisfactory to the beneficiary/client. The beneficiary/client may, at this time or any other, rescind the request.

4.4.2 Frequent or repeated requests or an insufficient number of providers may be reasons why Program Managers cannot accommodate a beneficiary/client for a change of provider. Program Managers will document these reasons in Section 3 of the "Request for Change of Provider form.

4.5 Within ten (10) working days of receipt of the "Request for Change of Provider" form, the Program Manager shall attempt to verbally notify beneficiary/client of the outcome, followed by the appropriate written confirmation. (Attachments III & IV)

4.5.1 The appropriate written confirmation of notification shall be **maintained in a separate administrative file** and retained for two years.

4.5.2 If the beneficiary/client is not satisfied with the outcome of the request, he/she may pursue the MHP's Resolution Process and file a complaint or grievance. The beneficiary/client may also file for a State Fair Hearing with the Department of Social Services.

4.6 A beneficiary/client requesting to change a Local Mental Health Plan network provider shall contact the Beneficiary Services Program in the Patients' Rights Office.

4.6.1 Beneficiary Services staff shall maintain a "Request to Change Provider Log".

4.6.2 Within ten (10) working days of receipt of the "Request for Change of Provider" form, Beneficiary Services staff shall provide the beneficiary/client with alternative names of network providers in the area of choice.

4.6.3 The "Request to Change Provider Log" shall be retained by the Beneficiary Services Program for two years.

AUTHORITY

Title 9; California Code of Regulations (CCR), Section 1830.225
Title 9; CCR, Section 1830.205
State Department of Mental Health Information Notice No. 01-05

ATTACHMENTS

Attachment I	Request for Change of Provider
Attachment II	Request to Change of Provider Log
Attachment III	Request to Change Provider response letter (unable to grant request)
Attachment IV	Request to Change Provider response letter (to schedule appointment)

REVIEW DATE

This policy shall be reviewed of or before January 1, 2008.

County of Los Angeles – Department of Mental Health
Local Mental Health Plan
REQUEST FOR CHANGE OF PROVIDER
CONFIDENTIAL

To request a change in your current provider, please submit this form to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a decision within 10 working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated or county contracted program, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-4949. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a decision on your request within 10 working days or you disagree with the decision, you may file a formal grievance.

SECTION 1 CURRENT PROVIDER INFORMATION (Clients please fill out Section 1 & 2 ONLY)

DATE:_____SERVICE LOCATION:_____

PROVIDER NAME:_____

SECTION 2 BENEFICIARY/CLIENT INFORMATION

Client Name:_____Birthdate:_____

Address:_____City:_____State:_____/ZipCode:_____

Phone Number:_____

1. I am requesting a change in:
   - ❑ Service Staff ☐ Medical Staff ☐ Program

2. Please describe the reason(s) for requesting a change. (**This information is optional)**

_____

_____

_____

_____

3. Have you discussed your concerns with your current provider?
   - ❑ Yes (Please describe what you have done to try to resolve the problem)

_____

_____

_____

   - ❑ No

_____

I understand that I will be contacted about this request within 10 working days.

I prefer to be contacted by: Mail ☐ Telephone ☐ Email ☐

Today's Date:_____

Signature of Person making request_____

Parent/Guardian Signature if request is by/for a child or youth:_____

SECTION 3 **AUTHORIZED COUNTY USE ONLY**

Clinical Data

DSM-IV

Axis I_____

Axis II_____

Axis III_____

Axis IV_____

_____

Medications: Specify dosage and frequency:_____

REVIEWED BY:_____

DATE:_____

RECOMMENDATION:_____

_____

_____

_____

Referral To:_____Notified:_____Date:_____

Appointment:_____Beneficiary/Client Contacted:_____

RFCOP2
LA

Name _____**MIS#**_____

Facility/Practitioner:_____

Los Angeles County – Department of Mental Health

Mental Health Plan – Department of Mental Health
REQUEST TO CHANGE PROVIDER

MONTHLY LOG

This log is to be maintained by each Program Manager for the program(s) for which he/she is responsible. A completed entry shall be made for each "Request for Change of Provider" form received during each month. A copy shall be sent to the Beneficiary Services Program in the Patients' Rights Office by the tenth (10^{th}) working day following the month for which the log is completed.

Month_____ Year_____

Check here if no requests were received during this month [ ]

DATE RECEIVED	DATE OF REQUEST	CONSUMER NAME	CURRENT PROVIDER	NEW PROVIDER	REASON FOR REQUEST (If Pt. willing to state)	REASON WHY REQUEST NOT GRANTED

6/6/02 RTCP

_____ _____ _____

REPORTING UNIT PROGRAM MANAGER DATE

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled	**Name** _____**MIS#**_____ **Facility/Practitioner:**_____ **Los Angeles County – Department of Mental Health**

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

DAVID MEYER
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

BOARD OF SUPERVISORS
GLORIA MOLINA
YVONNE BRATHWAITE BURKE
ZEV YAROSLAVSKY
DON KNABE
MICHAEL D. ANTONOVICH

DEPARTMENT OF MENTAL HEALTH

http://dmh.co.la.ca.us

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: Name of Agency
Telephone Number
Fax:

#200.2 Attachment III

Date

Name
Address
City, State, Zip Code

REF: REQUEST TO CHANGE PROVIDER

Dear_____:

This is to confirm our recent conversation regarding your request to change providers.

I am not able to grant your request at this time due to the following reason (s):

_____
_____
_____
_____
_____
_____
_____
_____
_____

You currently have an appointment scheduled with (staff name) for (day/date) at (time).

If you have any questions or concerns, please feel free to call me.

Sincerely,

Program Manager

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

DAVID MEYER
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

BOARD OF SUPERVISORS
GLORIA MOLINA
YVONNE BRATHWAITE BURKE
ZEV YAROSLAVSKY
DON KNABE
MICHAEL D. ANTONOVICH

DEPARTMENT OF MENTAL HEALTH

http://dmh.co.la.ca.us

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: Name of Agency
Telephone Number
Fax:

#200.2 Attachment IV

Date

Name
Address
City, State, Zip Code

REF: REQUEST TO CHANGE PROVIDERS

Dear _____:

This is to confirm our recent conversation regarding your request to change providers.

Your new provider is (staff name).

An appointment has been scheduled for (day/date) at (time).

If you will not be able to keep this appointment, please notify our office by calling (phone number).

Sincerely,

Program Manager